

Alpenverein Weltweit Service

Important additional information on claims for rescue costs and abroad incurred repatriation and medical treatment costs!

In order to settle your claim as quickly as possible, please note:

Filling in the claim form

- Fill in both pages of the claim form **completely**.
- The **original signature** on the bottom of the last page is mandatory.

Existence of other insurances

To be able to keep the insurance coverage of the Alpenverein Weltweit Service in this form and to these conditions we aim to reduce costs with co-insurances. For this we need your help!

Therefore please disclose following information/data:

Any existing private health or accident insurances, memberships with other alpine associations, ski federations or credit cards. In case you do not possess any of the aforementioned we ask you to answer the respective question with "No".

Submitting invoices of rescue costs

- Please send the original invoices of rescue costs to us **by post**, together with any reports of the helicopter or rescue team. **Only originals will be accepted.** Copies and emails cannot be accepted.
- Do not pay those invoices instead forward the original invoices to us **by post**.
- Should you receive a reminder, please also forward it to us immediately.

Submitting invoices for medical treatment abroad

- Please send the original invoices for medical treatment costs which have occurred abroad to your obligatory health insurance first.
- After receiving either a remuneration or refusal by your health insurance, forward the respective confirmation to us together with a copy of the invoice. In case of a refusal the insurance needs the letter of rejection as well as the original invoice. Please send those documents to our office by post. The reimbursement of costs can **only** be made upon submission of a service letter (also rejection) of your obligatory health insurance.
- Please inform us which of the submitted invoices you have already paid.



The present contract is an Austrian contract to which Austrian law must be applied in any case, with the exclusion of the Austrian Private International Law and International Reference Provisions.

Neither Österreichischer Alpenverein (ÖAV) nor KNOX Versicherungsmanagement GmbH have legal liability for the accuracy or content of any other than the information available in German version of the website or on the German information folder. In case of uncertainty, only the original German version is legally binding on Österreichischer Alpenverein. Translations are merely offered as a service for the members of Österreichischer Alpenverein and without legal obligation.

For all contracts concluded with Österreichischer Alpenverein, Austrian law must be applied, with the exclusion of the Austrian Private International Law and International Reference Provisions.

Please send your claim form together with all documents to:

**KNOX Versicherungsmanagement GmbH
Resselstraße 33
A-6020 Innsbruck**

**Tel.: +43 (0) 512 238300-30
Fax: +43 (0) 512 238300-15
E-Mail: av-service@knox.co.at**

Are there any private health insurances? Yes No If yes, which one?

insurance company _____ policy number _____

Are there any private accident insurances? Yes No If yes, which one?

insurance company _____ policy number _____

Which police station or rescue service has recorded the accident?

Is the person concerned or for minors a parent:

a) a member or supporting member of the Austrian mountain rescue system (ÖBRD)? Yes No

If yes, please state federation and membership number: _____

b) a member of the Austrian Ski Federation, Friends of Nature, the Austrian Automobile, Motorcycle or Touring Club? Yes No

If yes, please state federation- and membership number: _____

c) holder of credit cards such as VISA, Mastercard, etc.? Yes No

If yes, please state card number and Card (e.g. VISA): _____

d) holder of a ski-lift card called "Freizeitticket Tirol"? Yes No

If yes, please state card number and attach a copy of the card: _____

e) holder of Alpenverein-Premium-Single Trip Cover? Yes No

If yes, please state policy number: _____

Did you already pay the submitted invoices? Yes No

If yes, which of the submitted invoices?

Please provide your bank details (IBAN and BIC):

Account number (IBAN) _____

BIC _____

Name and address of the bank

Privacy data consent declaration

I herewith declare Generali Versicherung AG and KNOX Versicherungsmanagement GmbH and each of their affiliates to subject my insurance case related personal health information ("sensitive data"/"Sensible Daten") to being collected, processed and handled by the above mentioned. This for the purpose of settlement of the damage event, statistical surveys and for the purpose of assessing the contractual obligation.

Scope of information required

Information required are the detailed information by the named doctors, medical institutions as well as other facilities for patient care or health care, necessary for assessing the liability concerning illnesses, serious injury to health, clinically significant degeneration, infirmities and consequences of an accident related to this particular insurance case. This also includes medical documents that are essential for assessment (information on the reason of hospitalisation or out-patient treatment, on possible reasons for accident, on treatment services rendered, on duration of hospitalization or treatment as well as information on completion of treatment and discharge of hospitalization; anamnesis of the current treatment/hospitalization and status information, diagnostic results, surgical report, medical progress report, discharge summary, forensic results, etc.) and also operation and authority reports. Furthermore, I authorize Generali Versicherung AG and KNOX Versicherungsmanagement GmbH and each of their affiliates to view all documents of authorities (police, court, etc.) concerning this insurance case. To be able to assess the liability, I also agree that the insurer obtains all information necessary on, at the time of the insured event, already requested, existing or terminated personal insurances at social insurance providers, public funds for health financing and private insurance companies (with regard to double insurances).

Consequences of cancellation

Place and date _____

Moreover, I have been instructed that this authorization can be revoked at any time. In the case of a later revocation, all data ascertainment, data transmission and evaluation will stop within the moment of revocation. I have been informed that in the case of refusal or a later revocation of this agreement, the policyholder or the person(s) insured is (are) responsible for acquisition of the data required for evaluation and settlement of the claim of this particular insured event and for their transmission to the insurer; I have also been informed that no claims for benefits shall be due before the insurer has received the data required to assess the obligation to perform. If data ascertainment, data transmission or evaluation of already transmitted data remain partly or completely undone, it may lead to the release of the insurer from his obligation to perform.

Release from obligation of confidentiality

The policy holder or the person(s) insured or entitled to benefit release(s) the abovementioned people consulted in advance of any medical or other job-related confidentiality to the extent of the declaration of consent. By my signature, I confirm to have completely and truthfully answered the above questions and that this notification of claim is correct. I acknowledge that due to the terms and conditions of the insurance policy applicable on this notification of claim and this insurance case, any incorrect statements constitute a violation of duties, which may lead to the loss of my entitlement to benefits. With my signature, I confirm that I have answered the questions expressed truthfully and completely and that the record is correct. I acknowledge that statements that are false in terms of the insurance conditions that are valid for my contract are a violation of duties, which can lead to the loss of my entitlement to benefits.

Signature of the person insured
(signed in one's own handwriting)

Please send this claim form to: **KNOX Versicherungsmanagement GmbH, Resselstraße 33, A-6020 Innsbruck**

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